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Office of Administrative Law Judges
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Issue Date: 05 May 2005

Case No. 2003-BLA-6478

In the Matter of:
DANNY H. BENTLEY,
Claimant,

v.

B & G MINING, INC.,
Employer,
and
OLD REPUBLIC INSURANCE CO.,
Carrier,

and
DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

BEFORE: THOMAS F. PHALEN, JR.
Administrative Law Judge

APPEARANCES:
William Lawrence Roberts, Esq.
On behalf of Claimant

Lois A. Kitts, Esq.
On behalf of Employer

DECISION AND ORDER – AWARD OF BENEFITS

This is a decision and order arising out of a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901-962, ("the Act") and the regulations thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.[1]

[1] The Department of Labor amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at 65 Fed. Reg. 80, 045-80,107 (2000)(to be codified at 20 C.F.R. Parts 718, 722, 725 and 726). On August 9, 2001, the United States District Court for the District of Columbia issued a Memorandum and Order upholding the validity of the new regulations. All citations to the regulations, unless otherwise noted, refer to the amended regulations.

On August 6, 2003, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs, for a hearing. (DX 34).[2] A formal hearing on this matter was conducted on October 26, 2004, in Pikeville, Kentucky by the undersigned Administrative Law Judge. All parties were afforded the opportunity to call and to examine and cross examine witnesses, and to present evidence, as provided in the Act and the above referenced regulations.

ISSUES[3]

The issues in this case are:

1. Whether the claim was timely filed;

2. Whether Miner worked at least 29 years in or around one or more coal mines;

3. Whether the Miner has pneumoconiosis as defined by the Act;

4. Whether the Miner's pneumoconiosis arose out of coal mine employment;

5. Whether the Miner is totally disabled;

6. Whether the Miner's disability is due to pneumoconiosis;

7. Whether the Claimant has one dependant for purpose of augmentation; and

8. Whether the named employer is the Responsible Operator.

(DX 34).

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

Danny Bentley ("Claimant") was born on June 15, 1951; he was 53 years-old at the time of the hearing. (DX 14, 22: 4; Tr. 12). On his application for benefits, Claimant stated that he engaged in coal mine employment between 14 and 29 years. (DX 1). Claimant's last coal mine

[2] In this Decision, "DX" refers to the Director's Exhibits, "EX" refers to the Employer's Exhibits, "CX" refers to the Claimant's Exhibits, and "Tr." refers to the official transcript of this proceeding.

[3] Whether this claim was a subsequent claim was left open. Upon review of the record, I find no evidence of a prior claim, with exception of the statement by the Director concluding that this is a subsequent claim, DX 26, and Employer's objection to withdrawal "[i]n the event that the claimant has previously filed a claim." DX 23. Therefore this is an initial claim for benefits under the Act. Also, Employer listed other issues that will not be decided by the undersigned; however, they are preserved for appeal. (Item 18 DX 34).

employment was as an underground roof bolter operator. (DX 4; Tr. 14). Claimant described the physical requirements of the work to include sitting for one hour per day, crawling 2 miles for nine hours per day, lifting as much as 60 pounds, 10 times per day, and carrying as much as 50 pounds, 10 feet, five times per day. (DX 4; Tr. 14). Claimant had previously worked as a shuttle car operator and a beltman. (DX 3). Claimant last worked in and around coal mines in 1992, but quit after suffering a back injury. (DX 1; Tr. 18). He received a $12,000 settlement in 1993 as a result of his for Kentucky Black Lung benefits claim (DX 1, 6), and receives total disability benefits as a result of his back injury. (DX 22:6; Tr. 20-21).

Procedural History

Claimant filed a claim for benefits under the Act on August 20, 2001. (DX 1). On April 23, 2003, the District Director, Office of Workers' Compensation, issued a Proposed Decision and Order Denial of Benefits. (DX 26). The Director found that while Claimant suffers from pneumoconiosis and his pneumoconiosis was caused, at least in part, by work in coal mines, Claimant is not totally disabled due to pneumoconiosis. (DX 26). On April 28, 2003, Claimant requested a formal hearing. (DX 27). On August 6, 2003, this matter was transferred to the Office of the Administrative Law Judges. (DX 34).

Concerning prior claims, On June 21, 2002, Employer submitted a letter adding to its controversion an objection to the regulation allowing withdrawal of a prior claim to the extent that it deprives the employer of vested rights established in prior litigation of the claim. (DX 23). The Director's Proposed Decision and Order stated that this was a subsequent claim. (DX 26). Also, while Claimant marked that he had previously filed a claim for federal black lung benefits, he also included that his former claim had been withdrawn. (DX 1). Therefore, based on Claimant's notations, and since there is no evidence of a prior claim in the record for this proceeding, I find that this is an initial claim for benefits under the Act.

Dependency

On December 30, 1971, Claimant married Lou Ann Akers. (DX 1, 7, 22:4; Tr. 12, 19-20). Claimant has no dependent children. (DX 1, 22:5; Tr. 19-20). Therefore, I find Claimant has one dependant for purposes of augmentation.

Timeliness

Under Section 725.308(a), a claim of a living miner is timely filed if it is filed "within three years after a medical determination of total disability due to pneumoconiosis" has been communicated to the miner. Section 725.308(c) creates a rebuttable presumption that every claim for benefits is timely filed.

There is no evidence in the record that claimant received the requisite notice more than three years prior to filing his claim for benefits. Therefore, I find that this claim was timely filed.

Length of Coal Mine Employment

Claimant was a coal miner within the meaning of § 402 (d) of the Act and § 725.202 of the regulations.

The determination of length of coal mine employment must begin with § 725.101(a)(32)(ii), which directs an adjudication officer to ascertain the beginning and ending dates of coal mine employment by using any credible evidence. There are several permissible sources of credible evidence. First, an administrative law judge may rely solely upon a coal mine employment history form completed by the miner. *See Harkey v. Alabama-By-Products Corp.*, 7 B.L.R. 1-26 (1984). A miner's uncontradicted and credible testimony may also be the exclusive basis for a finding on the length of miner's coal mine employment. *See Bizarri v. Consolidation Coal Co.*, 7 B.L.R. 1-343 (1984); *Coval v. Pike Coal Co.*, 7 B.L.R. 1-272 (1984). If the miner's testimony is unreliable, it is permissible for an administrative law judge to credit Social Security records over the miner's testimony. *See Tackett v. Director, OWCP*, 6 B.L.R. 1-839 (1984).

On his application for benefits, Claimant stated that he engaged in coal mine employment between 14 and 29 years. (DX 1). At the hearing, however, Claimant testified that he has worked in coal mines for approximately 15 years. (Tr. 13). In addition, his Form CM-911a reflects full-time coal mine employment with multiple employers from January 1974 through June 1978, from January 1982 through April 1983, and from January 1984 through March 1992, for a total of approximately 14 years of coal mine employment. (DX 3). Finally, the Director concluded that Claimant had 14 years of coal mine employment based on his Social Security Earnings record. (DX 26).

The Social Security Earnings report reflects the following coal mine employment earnings history:

Year	Earnings	Industry Average for 125 days of CME	Years of Coal Mine Employment
1970	$ 40.00	$ 4,777.50	.01
1971	$ 162.50	$ 5,008.75	.03
1974	$ 8,752.51	$ 6,080.00	1.00
1975	$12,332.43	$ 7,405.00	1.00
1976	$14,029.04	$ 8,008.75	1.00
1977	$15,612.04	$ 8,987.50	1.00
1978	$ 7,240.60	$10,038.75	.72
1982	$16,771.17	$12,698.75	1.00
1983	$ 3,650.68	$13,720.00	.26
1984	$14,940.15	$14,800.00	1.00
1985	$30,038.48	$15,250.00	1.00
1986	$31,796.15	$15,390.00	1.00
1987	$30,265.31	$15,750.00	1.00
1988	$20,956.08	$15,940.00	1.00

1989	$28,158.14	$16,250.00	1.00
1990	$41,744.41	$16,710.00	1.00
1991	$45,832.88	$17,080.00	1.00
1992	$ 9,886.71	$17,200.00	.57
Total years of coal mine employment			14.62

Therefore, based on the Social Security Earnings records, I find that Claimant's length of coal mine employment is 14.62 years.

Claimant's last employment was in the Commonwealth of Kentucky; (DX 3; Tr. 18), therefore, the law of the Sixth Circuit is controlling. [4]

Responsible Operator

Liability under the Act is assessed against the most recent operator which meets the requirements of §§ 725.494 and 725.495. At his deposition, Claimant testified that he worked for B & G Mining, Inc., from October 31, 1989 to March 9, 1992. (DX 22:14). While he did receive checks from two employers, he contends that B & G Mining, and Producer Services are the same company. (DX 22:14-16). This is because his regular wages were paid by B & G Mining, but his overtime wages were paid by Producer Services. At the hearing, he reiterated that B & G Mining, Inc. was his last coal mine employer. (Tr. 18).

The District Director identified B & G Mining, Inc., as the putative responsible operator because it was the last operator to employ Claimant for a year, and is financially capable of assuming liability for payment of benefits. (DX 17, 26). The Director based this conclusion on Claimant's W-2, his statement, and the Social Security Earnings record, and found Claimant to have worked for B & G Mining, Inc., from 1989 through March 9, 1992. (DX 17, 26).

On October 25, 2001, B & G Mining, Inc., filed an amended Operator Response, accepting liability. (DX 21). But in its August 13, 2002 response to Director's Schedule for Submission of Additional Evidence, B & G Mining again contested its designation as responsible operator, (DX 25), and continued to contest this issue at the hearing. (Tr. 12). B & G Mining, Inc., however, has failed to put forth any evidence supporting its contention, and has failed to provide any reason why the Claimant's Social Security Earnings records and statements should not be considered. Therefore, after review of the record, I find that B & G. Mining, Inc. is properly designated as the responsible operator in this case.

[4] Appellate jurisdiction with a federal circuit court of appeals lies in the circuit where the miner last engaged in coal mine employment, regardless of the location of the responsible operator. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200 (1989)(en banc).

MEDICAL EVIDENCE[5]

[5] The most complex aspect of this claim arises with regard to the contentions surrounding the introduction of medical evidence. As opposed to responding individually to each of the motions, the undersigned has decided to handle the disputes in the context of this Decision and Order. In light of the past communications and motions, I understand the parties' arguments, and feel that there is nothing to be gained from further delay in issuing a decision. In fact, it is clear that any additional clarification by the undersigned will only lead to further disputes and hair splitting, which does not serve the interests of justice.

The evidentiary disputes can be broken into two categories. First, are the arguments surrounding Dr. Fino's post-hearing deposition. Second, are the objections to Employer's submission of evidence in excess of § 725.414. Since the issues are so intertwined, I will first review their development over the past six months, and will then rule on them together. Also, while I make my findings concerning the admissibility of evidence below, some of that discussion must be repeated in this note so that it is clear that I considered all aspects of the evidence before reaching a decision on the matter.

The procedural history surrounding the deposition of Dr. Fino on February 14, 2005 is convoluted. Dr. Fino was initially deposed on April 19, 2004. On October 6, 2004, Employer submitted a Motion for Continuance, requesting additional time to have its expert review recently submitted Claimant's evidence, some of which was yet to be received. This motion included no mention of a second deposition of Dr. Fino, but simply requested a continuance so that Employer could "fully develop" its defense. Claimant responded on October 7, 2004 with Plaintiff's Objection to Motion for Continuance, arguing that the claim had been pending for four years, which was plenty of time to make evidentiary requests. Ironically, Claimant also requested that if a continuance was granted, that he be given an additional 60 days post-hearing to rebut Employer's evidence, thus further delaying the ultimate decision. On October 12, 2004, the undersigned held a conference call, which resulted in giving the parties time to submit additional evidence, but denied Employer's request for continuance. On October 13, 2004, Employer submitted a Motion to Take and Submit Deposition of Dr. Gregory Fino Post-Hearing, alleging that Dr. Fino was not available for a second deposition until December 14, 2004.

The hearing was held by the undersigned on October 26, 2004 in Pikeville, Kentucky. Counsel for the Employer submitted Exhibits 1-10 into evidence, including an index page. (Tr. 9). Claimant did not object, but reserved the right to submit rebuttal and rehabilitative evidence. (Tr. 11). At that point, the undersigned admitted Employer's 1-10 into evidence, noting a reservation for additional exhibits from both parties.

Employer's exhibit list contained two exhibits designated in bold typeface. The first was a deposition of Dr. Wiot taken the day before the hearing. Since the transcript was not available at the time of the hearing, Employer reserved EX 8 for its eventual submission. Next, Employer designated EX 9 for the eventual submission of a second deposition by Dr. Fino that was scheduled for December 4, 2004. While the undersigned was dealing with the subject of extension, the parties were instructed to work together in order to get all evidence in by December 29th. (Tr. 29). Furthermore, the undersigned told counsel for Claimant "to assist in getting Dr. Rogers' notes or a date from Dr. Rogers for a deposition." However, while Employer's index page made it clear that Employer intended to depose Dr. Fino post hearing, and not Dr. Rogers, and there was no objection, Claimant proceeded to schedule a deposition of Dr. Rogers for Employer. On November 22, 2004, Claimant's counsel sent a letter informing the undersigned that he had fulfilled his obligation per the undersigned's hearing directive by scheduling the deposition of Dr. Rogers for November 1st, continued for November 8th, but that counsel for Employers canceled the deposition. Despite the undersigned's misstatement concerning which physician was to be deposed, Claimant should not have been surprised by the fact that Dr. Rogers' deposition was canceled.

On November 19, 2004, Employer filed a Motion for Extension of Time to Extend the Post-Hearing Deadlines, notifying the undersigned that Claimant had requested Dr. Fino's deposition be rescheduled due to a scheduling conflict, and that deposition was re-scheduled for January 25, 2005, which was outside the post-hearing deadline. Employer noted that Claimant did not oppose this motion. The undersigned responded by issuing an Order dated November 30, 2004, granting an extension until February 24, 2005 to submit medical evidence.

On December 20, 2004, Complainant submitted an Objection to Amend Notice to Take Deposition dated December 20, 2004, alleging that upon receipt of the hearing transcript, he found no indication that the undersigned had left the record open to take the deposition of Dr. Fino, Claimant argued that since time was allowed to take the deposition of Dr. Rogers, and Claimant's counsel had been so kind as to schedule that deposition for Employer, which was ultimately canceled by Employer, then Employer's motion should be denied. Additionally, Claimant requested that if time was extended for the second deposition of Dr. Fino, that he be given additional time to respond. Employer's Response to Claimant's Objection to Amended Notice To Take Deposition, laid out the procedural history surrounding the scheduling or Dr. Fino's deposition, including the undersigned's granting of two extensions to submit additional evidence.

On January 20, 2005, the undersigned issued an Order stating that unless the parties jointly agreed in writing on submission dates for additional evidence, no further submissions or extensions would be granted. Furthermore, the undersigned exempted from the agreement requirement any evidence that was "submitted and received at the hearing on October 26, 2004." Finally, the undersigned concluded that unless there was a joint agreement, all evidence was due by January 29, 2005.

Employer submitted its Black Lung Benefits Act Evidence Summary Form under cover dated January 28, 2005. Arguing that the "justice system" was headed for "destruction." Employer again contended for the submission of Dr. Fino's deposition, and protested the shortening for the submission of evidence date from February 24, 2005 until January 29, 2005, asserting the conference call and order as authority. Claimant responded by letter dated February 4, 2005, alleging that the only reason he gave consent to an extension for Dr. Fino's deposition was because he was under the mistaken belief that the "transcript" had allotted additional time for this purpose. Upon receipt of the transcript, however, it is apparent that Claimant's counsel seized on the undersigned's misstatement regarding Dr. Rogers instead of Dr. Fino, and objected to the deposition. Furthermore, Claimant contended that Employer was trying to take Dr. Fino's deposition in an attempt to get additional medical evidence into the record which was not allowed by the regulations. Claimant followed his letter with an Objection to Deposition of Dr. Fino and Motion to Strike Deposition of Fino, dated February 23, 2005, arguing that the undersigned had stated "that the second deposition of Dr. Fino could not be submitted as evidence." To clarify, however, I must point out that I never said that Dr. Fino's deposition could not be taken, only that the parties "were unable to agree on what they have agreed upon regarding post-hearing submissions," and absent agreement to the contrary, no evidence received subsequent to the close of evidence date set at the hearing would be admitted.

Undeterred, Employer submitted a Motion to Reopen the Record, dated February 24, 2005, which included a copy of Dr. Fino's February 14, 2005 deposition, and again detailed its arguments for its admission. Claimant responded with an Objection to Motion to Reopen Record, dated March 1, 2005, in which he repeated his prior arguments and attached copies of all of his prior objections on this matter.

Turning now to the second issue, Claimant submitted his Objection to Medical Reports Submitted in Prior Federal Black Lung Claim, dated February 28, 2005, objecting to portions of EX 2, 7, and 8 on the grounds that this is rebuttal evidence to the prior application filed on November 6, 1999, and cannot be considered in regards to a subsequent claim. Also, Claimant contended that this evidence exceeded the limitations imposed by §725.414.

On March 18, 2005, Employer filed its Response to Objection to Medical Reports Submitted in Prior Federal Black Lung Claim, arguing that this is a subsequent claim, and under *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994), the undersigned must consider all of the new evidence, and if there is a material change, then he must reconsider all of the evidence of record to determine whether the evidence supports entitlement to benefits. Next, Employer contended that Claimant's objection was too late and therefore was waived. Finally, Employer stated that its due process rights would be violated if all of the evidence, from both the new and old claims, was not considered.

On March 28, 2005, Claimant filed his Response to the Defendant-Employer's Response to Object to Medical Reports Submitted in Prior Federal Black Lung Claim, arguing again that this is a subsequent claim filed under the amended regulations, and that as such, *Sharondale* and §725.309 (d) were inapplicable. He next reiterated that the limitations advanced by the amended regulations must apply, and that Employer's evidence exceeded those limitations. Finally, Claimant contended that his February 28, 2005 objection was not too late since he did not

receive Employer's summary form until after January 28, 2005, the record was left open for submission of medical evidence until February 24, 2005, briefs were due March 2, 2005, and that he could not make his objection prior to the date of submission.

To simplify resolution , the undersigned will deal with these issues out of order. Claimant's Objection to Medical Reports Submitted in Prior Federal Black Lung Claim is overruled because, as determined above, there is no evidence of a prior claim. As a result, this is a new claim and the parties' discussion of modification or subsequent claim standards is irrelevant.

While I have overruled Claimant's objection, his argument concerning the limitations of §725.414 has merit. Typically, as Claimant argues, in a black lung proceeding, the undersigned admits all evidence into the record at the hearing, and then upon close of evidence and submission of briefs, reviews the parties submissions, Black Lung Benefits Act Summary Evidence Forms, and briefs to determine the evidence designated by each of the parties, whether any of the evidence exceeds the limitations or quality requirements, and whether either party has argued "good cause" for exceeding the limitations. (I note, however, that Claimant's reliance on the February 24, 2005 close-of-evidence date is suspect considering his reliance on my January 20, 2005 order which closed evidence submission on January 29, 2005. Also, I noticed that while Claimant states that it has a right to see Employer' brief before contesting evidence, he submitted its objection five days prior to Employer filing its brief.) As a result, while evidence may be admitted into the record at hearing, this does not automatically mean that it is admitted into evidence for consideration in the final decision and order. As a result, Employer's argument that Claimant objected too late and therefore waived his right to contest evidence, is irrelevant. The undersigned will always review the medical evidence and make *sua sponte* determinations of admissibility.

Reviewing Employer's exhibits 1-10, I find that a number of its exhibits exceed the limitations of §725.414. Specifically, I find that portions of EX 2, 7, 8, and 9 exceed the limitations. For purposes of dealing with the immediate issue, I will briefly discuss in this note which aspects are not admissible into evidence. A more detailed discussion of my reasons, however, can be found in subsequent portions of this Decision and Order. Concerning EX 2 and 9, I find Dr. Fino's objective testing, his review of the CT scans, and his conclusions concerning total disability are admissible under the regulations. On the other hand, I find that his medical narrative report is not admissible because he considers a number of chest x-rays, examination reports, and test results which were not admitted into evidence. Therefore, while the report is admissible as a narrative medical report under the limitations of §725.414, large portions of the report is not. Also, I do not distinguish between Dr. Fino's narrative report and deposition, because I found the deposition to be nothing more than a restatement of the written report.

Concerning EX 7 and 8, with exception of Dr. Wiot's readings of the August 8, 2000 and January 13, 2000 CT scan, and his reading of the November 16, 2001 x-ray, I find all of his x-ray readings and his narrative discussion to be inadmissible into evidence because they exceed the limitations of §725.414. Furthermore, while his readings of Claimant's treatment x-rays may be admissible, as they are not limited by the regulations, these treatment x-rays are not admissible for quality reasons for the purpose of determining whether Claimant suffers from pneumoconiosis under §718.202 (a)(1). Therefore, I will not consider Employer's rebuttals because there is no usable x-ray evidence to rebut. I do not distinguish between the narrative report of Dr. Wiot and his deposition because he basically restates his prior written report, basing his conclusions on the same inadmissible evidence.

Considering the arguments of its experts, it is surprising that Employer did not argue "good cause" for submission of the serial x-rays in this claim. While its brief notes that "the normal 1996 x-ray interpretation is essential to a correct medical diagnosis in this case since it provides a serial view of the miner's lungs over time," and on numerous occasions in Drs. Wiot and Fino's deposition transcripts, they express the need for this information, Employer never argued "good cause" for exceeding the regulations. I also found no mention of "good cause" in the hearing transcript, any of the responses or motions submitted post-hearing, nor attached to the amended evidence summary form. Furthermore, I am unwilling to find "good cause," *sua sponte*, based in part on Employer's failure to make any kind of showing when Claimant objected to inclusion of excessive x-rays. Also, it would be arbitrary and capricious for the undersigned to let in all x-rays, and it would show bias for the undersigned to pick certain x-rays that salvage Drs. Wiot's and Fino's narrative reports. Therefore, despite ample opportunities to argue "good cause," and potentially adequate evidence for the undersigned to grant it, Employer never raises the

Section 718.101(b) requires any clinical test or examination to be in substantial compliance with the applicable standard in order to constitute evidence of the fact for which it is proffered. *See* §§ 718.102 - 718.107. The claimant and responsible operator are entitled to submit, in support of their affirmative cases, no more than two chest x-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two blood gas studies, no more than one report of each biopsy, and no more than two medical reports. §§ 725.414(a)(2)(i) and (3)(i). Any chest x-ray interpretations, pulmonary function studies, blood gas studies, biopsy report, and physician's opinions that appear in a medical report must each be admissible under § 725.414(a)(2)(i) and (3)(i) or § 725.414(a)(4). §§ 725.414(a)(2)(i) and (3)(i). Each party shall also be entitled to submit, in rebuttal of the case presented by the opposing party, no more than one physician's interpretation of each chest x-ray, pulmonary function test, arterial blood gas study, or biopsy submitted, as appropriate, under paragraphs (a)(2)(i), (a)(3)(i),

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issue. As a result, the undersigned will enforce the limitations of §725.414, and does not find "good cause" to make exceptions.

Turning now to the admissibility of Dr. Fino's February 14, 2005 deposition, despite Employer's counsel's propensity for the overdramatic, her procedural analysis was correct. The conflict was put into motion when the undersigned misstated at the hearing that Dr. Rogers was to be deposed. Despite the fact that neither counsel objected to the mistake, or called my attention to it, thus, technically waiving their objection, Claimant's counsel, who should have realized the mistake, hopped aboard and rode it about as far as he could, and Employer's counsel acted as though she had an inherent right to proceed with Dr. Fino's deposition as though she was not in the hearing room when she missed the mistaken identification of Dr. Rogers instead of Dr. Fino. The undersigned issued the January 20th Order believing that two experienced professionals could work things out on their own. Unfortunately, this only made things worse. Therefore, upon extensive review of the motions and responses affiliated with this issue, I find that Employer had properly requested the record be held open to admit Dr. Fino's second deposition. However, due to errors by the undersigned, and hyper-technicality by the Claimant, Employer's task was made much more difficult. Therefore, I admit into evidence the deposition of Dr. Fino dated February 14, 2005.

Admitting EX 9 into evidence, however, presents additional problems, but I do not believe them to be insurmountable. First, Claimant was so busy protesting Dr. Fino's deposition that he did not attend to conduct cross-examination. While it is not certain whether Claimant would have attended the deposition at all, considering that he did not participate in the deposition of Dr. Fino less than one year earlier, I must give him the benefit of the doubt and assume he would have. Second, as noted above, Claimant did not disagree with the record remaining open for additional time to submit medical evidence, as long as he was given sufficient time to respond to Employer's evidence. Admitting EX 9 post-brief, however, has effectively eliminated Claimant's opportunity to respond.

This situation leaves me with two choices. On the one hand, I can reopen the record for the purpose of allowing Claimant to respond, knowing full well that I will be deluged by both sides with motions and objections to every item presented by the other side. On the other hand, I can proceed to a decision on the merits, not allowing Claimant an opportunity to contest Dr. Fino's deposition.

Two facts, however, convince me that it is harmless to admit Dr. Fino's testimony into evidence despite Claimant's inability to respond. First, Dr. Fino's February 14, 2005 deposition does not add much beyond what was stated in his April 19, 2004 deposition, nor does it add anything that was not included in the September 29, 2004 narrative medical report. Since Claimant had ample opportunity to respond to both of these prior reports, there is no need to repeat the same defenses. Second, as stated above, while I admit Dr. Fino's deposition into evidence, almost all of the opinions he offered relied on additional x-rays and other evidence with was not admissible. As a result, I am unable to give most of his conclusions any kind or probative weight in the determination of Claimant's elements of entitlement.

or (a)(3)(iii). §§ 725.414(a)(2)(ii), (a)(3)(ii), and (a)(3)(iii). Notwithstanding the limitations of §§ 725.414(a)(2) or (a)(3), any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be received into evidence. § 725.414(a)(4). The results of the complete pulmonary examination shall not be counted as evidence submitted by the miner under § 725.414. § 725.406(b).

Claimant selected Dr. Imtiaz Hussain to provide his Department of Labor sponsored complete pulmonary examination. (DX 8). Dr. Hussain conducted the examination on November 16, 2001. I admit Dr. Hussain's report under § 725.406(b). I also admit Dr. Sargent's quality-only interpretation of the chest x-ray under § 725.406(c). (DX 13).

Claimant completed a Black Lung Benefits Act Evidence Summary Form. Claimant designated Dr. Forehand's complete pulmonary evaluation conducted on August 4, 2004. Claimant also included an x-ray interpretation of the February 2, 2004 film by Dr. Poulos, which does not meet the quality standards of §718.102.[6] Next, he included a medical report from Dr. Rogers dated September 27, 2004. As CT scan evidence, Claimant included reports by Dr. Rogers, Dr. Forehand, Dr. Poulos, and two reports by Dr. Halbert. Finally, as hospitilization records and treatment notes, Claimant included Dr. Rogers' office treatment notes from February 17, 2000 to present, hospitalization records from the Pikeville Methodist Hospital and Dr. Poulos dated February 2, 2004, and a treatment report from Dr. Kendrell dated October 10, 2002. With exception of the August 4, 2004 x-ray interpretation, Claimant's evidence complies with the requisite quality standards of §§ 718.102-107 and the limitations of § 725.414 (a)(3). Therefore, I admit Claimant's remaining evidence designated in its summary form.[7]

Employer completed a Black Lung Benefits Act Evidence Summary Form. Employer designated Drs. Fino and Dahhan's complete pulmonary examinations conducted on September 8, 2004 and October 14, 2003, respectively. As rebuttal x-ray evidence Employer submitted Dr. Wiot's interpretations of the following films: October 10, 2002; June 19, 2003; November 16, 2001; May 3, 2000; July 23, 1996; December 15, 1999; October 15, 1996; June 18, 1996; and May 3, 2000. Furthermore, Employer submitted Dr. Fino's interpretations of the November 18,

[6] See note 22 concerning x-ray evidence from hospitalization records.

[7] Claimant's exhibits are not organized in any particular order, and with exception of Dr. Forehand's report, all of the treatment records and medical reports are repeated multiple times within each exhibit and among the exhibits. While the record includes the one page report by Dr. Rogers dated September 27, 2004 (CX 2), it also includes reports from his dated April 6, 2004 (CX 6), and March 17, 2004 (CX 7). The April 6, 2004 report, appears to be a photocopy of the September 27, 2004 report, with exception of the date. The March 17, 2004 report, which does not appear to be a photocopy of the September 27, 2004 report, includes identical answers to each question. Next, Claimant's exhibits included two medical reports by Dr. Mattu dated March 3, 2004 (CX 7) and July 2, 2003 (CX 8), a report from Dr. Rogers dated November 8, 2003 (CX 1), and a report by a physician with an illegible signature dated February 10, 2003. (CX 7). Concerning admissibility of these reports, even though the reports from Dr. Rogers and Mattu state the duration of their treatment of Claimant, none of these documents mention that they are related in any way to Claimant's treatment. Second, all of the reports, with exception of the February 10, 2003 document, utilize the same form submitted by Dr. Rogers on September 27, 2004 that Claimant has called a medical report. Based on these factors, I find that February 10, 2003, July 2, 2003, November 8, 2003, March 3, 2004, March 17, 2004, April 6, 2004 physicians reports are all medical reports and not treatment records. As a result, inclusion of these reports would exceed the limitations of § 725.414 (a)(3). Therefore, I will consider only the September 27, 2004 report by Dr. Rogers and the August 26, 2004 report by Dr. Forehand that were designated on Claimant's summary form.

2001 film and the August 4, 2004 film. Next, Employer included the following CT scan interpretations: Dr. Wiot's readings of the August 8, 2000 and January 13, 2000 scans, and Dr. Fino's readings of the March 9, 2004, September 8, 2004, January 13, 2000, August 8, 2000, and June 25, 1996 scans. Finally, Employer included supporting depositions by Dr. Fino, Dr. Dahhan, and Dr. Wiot. Employer's evidence complies with the requisite quality standards of §§ 718.102-107, but not the limitations of § 725.414(a)(3). Employer is permitted to submit one rebuttal x-ray for each x-ray submitted by the opposing party, and one rebuttal of the Department-sponsored chest x-ray study. As a result, only Dr. Wiot's reading of the November 16, 2001 film, and Dr. Fino's reading of the August 4, 2004 film are admissible under the limitations of § 725.414(a)(3). Therefore, I admit the evidence Employer has designated in its summary form, with exception of Dr. Wiot's interpretations of the June 18, 1996; July 23, 1996; October 15, 1996; December 15, 1999; May 3, 2000; May 4, 2000; October 10, 2002; and June 19, 2003 films, and Dr. Fino's interpretations of the November 18, 2001 film.

X-RAYS

Exhibit	Date of X-ray	Date of Reading	Physician / Credentials	Interpretation
DX 12	11/16/01	11/16/01	Hussain	3/2 ps
DX 13	11/16/01	02/15/02	Sargent, BCR[8], B-reader[9]	Film Quality 3
EX 6,8	11/16/01	09/27/01	Wiot, BCR, B-reader	2/1 qt / Category A[10]

[8] A physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. *See* 20 C.F.R. § 727.206(b)(2)(III). The qualifications of physicians are a matter of public record at the National Institute of Occupational Safety and Health reviewing facility at Morgantown, West Virginia.

[9] A "B" reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the Department of Health and Human Services. This is a matter of public record at HHS National Institute for Occupational Safety and Health reviewing facility at Morgantown, West Virginia. (42 C.F.R. § 37.5l) Consequently, greater weight is given to a diagnosis by a "B" Reader. *See Blackburn v. Director, OWCP*, 2 B.L.R. 1-153 (1979).

[10] Dr. Wiot was deposed on December 9, 2003, continuing on October 25, 2004, where he reiterated the findings of his prior written report. (EX 8). Concerning the November 16, 2001 film, Dr. Wiot stated:

> If this was the only x-ray that I had I interpreted it as showing Q and T size opacities within the upper two zones bilaterally with a degree of profusion of two over one. And then in the right upper lung field there was a large opacity which would be classified as an A. So if I looked at this film alone I would have suggested that this was an individual with complicated coal workers pneumoconiosis… [But] you have to look at the sequence of events in this particular gentleman…. [A]s soon as you put the session, the sequence of events together, with nothing in '96 and significant change in '99, you immediately know that there's something else going on in this individual than coal workers' pneumoconiosis.

(EX 8: Dec. 9, 2003 Deposition at 21-25). Dr. Wiot goes on to conclude that based on a series of x-rays from 1996 through 2001, and CT scans, that Claimant does not have simple or complicated pneumoconiosis, but instead suffers from sarcoid. (EX 8: Dec. 9, 2003 Deposition at 25-26).

While the undersigned is not able to consider Dr. Wiot's ultimate conclusion concerning this x-ray because he considers it inadmissible evidence, I also find that it would take Dr. Wiot's interpretation out of context to use it to determine the presence of complicated pneumoconiosis based simply on the recorded ILO classification values.

EX 3,4	10/14/03	10/14/03	Dahhan, B-reader	2/2 qq
CX 5	08/04/04	08/04/04	Forehand, B-reader	1/2 pq / Category A
EX 1, 2	08/04/04	09/21/04	Fino, B-reader	2/1 qu / Category A[11]
EX 1, 2	09/08/04	09/21/04	Fino, B-reader	2/1 qu / Category A[12]

Therefore, I will exclude this x-ray interpretation for the presence or absence of simple or complicated pneumoconiosis under §718.202 (a)(1).

[11] Dr. Fino further explains the results of this x-ray in his October 6, 2004 medical narrative report, and again at his February 14, 2005 deposition. (EX 9). In the written report he states:

> My chest x-ray reading is consistent with both simple and complicated coal workers' pneumoconiosis. According to the ILO system, the reader interprets the chest x-ray according to that system if it is consistent with pneumoconiosis. However, in reviewing previous x-ray readings, this man went from a 0/0 or 0/1 chest film in 1996 to a 2/2. category A reading in 2000. That means this man went from a negative film to a very positive film within three years. That rapid progression over time would be exceedingly unusual to coal mine dust inhalation… [T]he series of chest films over time and the series of CT scans over time argue against the diagnosis of simple or complicated coal workers' pneumoconiosis. The rapid progression between 1996 and 1999 would not be consistent with a coal mine dust-related lung disease. I would be very concerned about sarcoidosis.

(EX 2). At his deposition he adds:

> The thing that's very important is just because you put an ILO classification on a film, it doesn't mean that it's pneumoconiosis. And, in fact, because we're in the federal black lung arena, you're required to use the ILO form and put down an ILO classification, but the ILO form clearly says you put something down if it is consistent with pneumoconiosis.
>
> Well, the fact exists that there are many other conditions besides pneumoconiosis that may look like it and could potentially be classified according to the ILO system. Now, what I would ask me if I were you, what do I think this guy has? Well, I think he's got one of two things. I think he's got sarcoidosis, which is a disease of general medical population characterized by changes similar to this but has nothing to do with coal mine dust inhalation, or the other possibility is that he has a granulomatosis vasculitis, which is a special kind of inflammation of blood vessels in the lungs that can cause this type of picture [that is unrelated to coal mine dust].

(EX 9 at 11-12). Dr. Fino goes on to conclude that there is insufficient medical evidence to justify a diagnosis of CWP.

As discussed above, while the undersigned is not able to consider Dr. Fino's ultimate conclusion concerning this x-ray because he considers inadmissible evidence, I also find that it would take Dr. Fino's interpretation out of context to use it to determine the presence of complicated pneumoconiosis based simply on the recorded ILO classification values. Therefore, I will exclude this x-ray interpretation for the presence or absence of simple or complicated pneumoconiosis under §718.202 (a)(1).

[12] This x-ray interpretation is excluded for the purpose of determining the presence or absence of simple or complicated pneumoconiosis under §718.202 (a)(1). *See* note 11.

PULMONARY FUNCTION TESTS

Exhibit/ Date	**Co-op./ Undst./ Tracings**	**Age/ Height**[13]	**FEV_1**	**FVC**	**MVV**	**FEV_1/ FVC**	**Qualifying Results**
DX 11 11/16/01	Good/ Good/ Yes	50 67”	2.95 2.91*	4.00 4.26*	105	74 68*	No No
EX 4 10/14/03	Good/ Good/ Yes	52 70.2”	3.76	4.84	120	78	No
CX 5 8/4/04	Not listed/ Not listed/ Yes	53 70”	3.18	4.59	92	69	No
EX 10 9/8/04	Fair/good/[14] Not listed/ Yes	53 70.3	2.69 3.09*	3.85 4.10*		70 75*	No No

* post-bronchodilator values

ARTERIAL BLOOD GAS STUDIES

Exhibit	**Date**	**pCO_2**	**pO_2**	**Qualifying**
DX 10	11/16/01	41.9 28.7*	67 108*	No No
EX 4	10/14/03	37.9 40*	86.5 92.9*	No No
CX 5	08/04/04	42 39*	71 63*	No No
EX 10	09/08/04	38.5	76.8	No

*post-exercise values

Narrative Reports

Dr. Imtiaz Hussain examined the Claimant on November 16, 2001. (DX 9). Based on symptomatology (sputum, wheezing, dyspnea, and cough), employment history (none listed), individual history (attacks of wheezing, chronic bronchitis, arthritis, allergies, and a collapsed lung in 1994), family history (high blood pressure, heart disease, diabetes, cancer, and stroke), smoking history (1/2 pack per day for 29 years, and continues to smoke), physical examination (bilateral rhonchi), chest x-ray (3/2), PFT (normal), ABG (hypoxemia), and an EKG (normal), Dr. Hussain diagnosed pneumoconiosis due to dust exposure. Based on the x-ray results,

[13] I must resolve the height discrepancy recorded on the pulmonary function tests. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). Therefore, I find that the miner’s actual height is 70 inches.

[14] Dr. Fino states that Claimant gave a better effort on the post bronchodilatory spirometry, and it was normal.

symptoms, and history of dust exposure, Dr. Hussain opined that this moderate impairment was caused by pneumoconiosis. Also, Dr. Hussain did not list cigarette smoking as a possible etiology of Claimant's condition. Finally, Dr. Hussain concluded that Claimant does not retain the respiratory capacity to perform the work of a coal miner or to perform comparable work in a dust-free environment due to his hypoxemia and effort intolerance.

Dr. Dahhan, an internist, pulmonologist, and B-reader, examined the Claimant on October 14, 2003 and submitted a report on October 30, 2003. (EX 3-4). Based on symptomatology (daily cough, intermittent wheeze, productive clear sputum, sleep apnea, dyspnea on exertion, and back pain), employment history (16 years underground coal mine employment, as a roof bolter, quitting in 1992 due to a back injury), individual history (appendectomy and disc surgery in 1994), smoking history (one pack per day since age 20, and continues to smoke), physical examination (good air entry to both lungs with no crepitation, rhonci or wheeze), chest x-ray (2/2), PFT (normal), ABG (normal), and an EKG (regular sinus rhythm with normal tracings), Dr. Dahhan diagnosed simple CWP. He opined that from a functional respiratory standpoint, there was no evidence of a pulmonary impairment or disability, and therefore, Mr. Bentley retains the physiological capacity to continue his previous coal mine work or job of comparable physical demand. He concluded that Claimant's low back pain, peptic ulcer disease, hyperlipidemia, allergic rhinitis and prostatism are not caused by, related to, contributed to, or aggravated by the inhalation of coal dust or CWP.

Dr. Dahhan was deposed by the Employer on April 20, 2004, when he repeated the findings of his earlier written report. (EX 5).

Dr. Randolf Forehand, a pediatrician and B-reader, examined the Claimant on August 4, 2004, and submitted a report dated August 26, 2004. (CX 3, 5). Based on symptomatology (shortness of breath, exertional and nighttime wheezing, sputum production, and exertional chest pain), employment history (16 years of coal mine employment, with 12 as a roof bolt operator, retiring in 1992), individual history (back injury, depression, hypercholesterolemia, and chronic musculoskeletal discomfort), family history (cancer), physical examination (no abnormalities identified), chest x-ray (2/1 – Category A complicate CWP), PFT (normal), ABG (no evidence of airflow limitation or occult airtrapping, and no arterial hypoxemia, but post exercise results are indicative of exercise-induced arterial hypoxemia), EKG (no acute changes), and a CT scan (summarized below), Dr. Forehand diagnosed complicated CWP. He opined that Claimant is totally and permanently disabled and unable to return to his last coal mining job. Finally, while Claimant's smoking was discussed in relation to the PFT (33 pack years of cigarette smoking, and currently smokes), no mention was made in conjunction with Dr. Forehand's diagnosis and conclusions.

Dr. Gregory Fino, an internist, pulmonologist, and B-reader, examined the Claimant on September 8, 2004, and submitted a narrative report on September 29, 2004. (EX 1-2, 10). His report summarized symptomatology (shortness of breath for 20 years, dyspnea upon exertion, chest pain, wheezing, daily cough and mucus production), employment history (16 years underground coal mine employment with 12 as a roof bolter, quitting in 1992 due to back injury), individual history (bronchitis but no pneumonia, tuberculosis, emphysema, asthma, bronchiectasis, or frequent colds), family history (high blood pressure, diabetes, black lung

disease and malignancy), smoking history (currently smokes one pack of cigarettes per day since 1972, but quit for a total of six years during this period of time), physical examination (bilateral rhonchi), chest x-rays (8/4/04 and 9/8/04 both showed 2/1 qu with Category A opacity[15]), PFT (mild air trapping but no evidence of a restrictive defect, and otherwise normal), ABG (normal) , and five CT scans (summarized below). In addition, Dr. Fino also considered a large number of documents as part of a comprehensive medical records review.[16] Dr. Fino failed to specifically diagnose any condition, stating that there was insufficient objective medical evidence to justify a diagnosis of CWP. Also, while Dr. Fino states that his x-ray reading is consistent with both simple and complicated CWP under the ILO system, he rejects this conclusion based on the serial x-rays (most of which were excluded from consideration due to exceeding the limitations), and CT scans. Ultimately he states that based on the rapid progression of Complainant's lung condition between 1996 and 1999, his findings are not consistent with coal-dust induced disease. Dr. Fino, however, states that he "would be very concerned about sarcoidosis, … a granulomatous lung condition unrelated to the inhalation of coal mine dust." Finally, he opined that regardless of the diagnosis, there was no evidence of any functional respiratory impairment or pulmonary disability based on the PFT results, and this lack of impairment is further evidence that he does not have a coal mine dust-induced lung disease. Therefore, from a respiratory standpoint, Mr. Bentley is neither partially nor totally disabled from returning to his last mining job requiring similar effort.

Dr. Fino was deposed by the Employer on February 14, 2005, when he repeated the findings of his earlier written report. (EX 9).

Treating Physician

At the October 24, 2001 deposition, Claimant stated that he sees Dr. Mettu approximately every three months for his lung condition. (DX 22:6-8). He also claimed to be under the care of Dr. Nichols, who he sees every six weeks, and Dr. Rogers, who he sees every three months. (DX 22:8-9;). Finally, Claimant stated that in 1996, for a period of about four months, he was treated by Dr. Bruce Broudy. (DX 22:10). At the hearing, Claimant testified that he has been under the

[15] Dr. Fino's interpretation of the November 18, 2001 x-ray was excluded above because it exceeded the limitations of §725.414.

[16] Dr. Fino's medical evidence review included the following admissible records: Drs. Mettu and Ammisetty office records from January 5, 2000 through November 25, 2002; January 13, 2000, August 8, 2000, and November 13, 2003 CT scans; Dr. Mettu's January 24, 2000 medical letter, chest x-ray, and CT scan; Dr. Rogers office records from February 17, 2000 through June 19, 2003; a pathology report dated February 24, 2000; Dr. Mettu's medical reports dated March 1, 2000, July 21, 2000, and x-ray reading dated June 21, 2000; Complainant's November 16, 2001 DOL examination; Dr. Kendall's x-ray reading dated October 10, 2002; a Pulse Oximetry report dated December 10, 2002; a medical form from Dr. Rogers dated January 18, 2003, Dr. Dahhan's examination report dated October 30, 2003; Dr. Forehand's report dated August 26, 2004; Dr. Halbert's x-ray interpretation dated June 19, 2003; and Dr. Rogers report dated September 27, 2004. Dr. Fino, however, also reviewed a large amount of evidence which was not admitted into evidence, and if it had been, would have exceeded the limitations of §725.414. This evidence includes the following: ten chest x-ray interpretations from Dr. Wiot of films dated June 18, 1996, July 23, 1996, October 15, 1996, December 15, 1999, February 23, 2000, May 3, 2000, May 4, 2000, July 13, 2000, September 22, 2000, and November 13, 2003; an x-ray reading dated June 21, 2000; DOL examination reports dated October 16, 2000 and September 12, 2001; an ABG dated October 22, 2001; medical forms dated March 5, 2002 and July 2, 2003; and a DOL history form dated February 10, 2003.

care of Dr. Rogers since February 2000, and that Dr. Mettu and Dr. Nichols were also his treating physicians. (Tr. 16-17).

Dr. Anthony Rogers submitted a medical report dated September 27, 2004. (CX 2).[17] He stated that he had treated Claimant from February 17, 2000 to present. Dr. Rogers diagnosed both clinical pneumoconiosis and legal pneumoconiosis with progressive fibrosis. Furthermore, he diagnosed complicated pneumoconiosis with progressive fibrosis based on chest x-rays that revealed nodular disease throughout both lungs. Dr. Rogers, however, did not designate which x-rays he relied upon to make his diagnosis. He opined that Claimant's condition has been significantly contributed to by dust exposure in coal mine employment. Also, Dr. Rogers concluded that Claimant was totally disabled due to his pneumoconiosis, and therefore, does not retain the respiratory capacity to perform the work of a coal miner or to perform comparable work in a dust-free environment. Dr. Rogers did not, however, discuss the length of Claimant's exposure to coal dust (noting only "years" of confirmed coal mine employment), exposure to tobacco smoke, or the objective testing relied upon to determine the extent of Claimant's pulmonary impairment.

CT Scans[18]

This is a comprehensive list of the 13 CT scans admitted into evidence. They are listed chronologically by the date the study was conducted.

June 25, 1996 – CT Scan report by Dr. Fino dated September 29, 2004: Significant elevation of the right diaphragm, but no nodular densities present consistent with simple CWP, and no evidence of complicated pneumoconiosis. (EX 2)

January 13, 2000 – CT Scan report by Dr. Dennis Halbert: There are small nodular opacities seen throughout all lung zones which are consistent with those seen in CWP. These are most prevalent in the upper lung zones. There are some areas of what appears to be a coalescence of these nodules in both apices. The density in the right apex is slightly larger than that in the left apex. I suspect that this represents the early stages of a large opacity secondary to complicated CWP. A very small nonspecific appearing infiltrate in the base is located posterolaterally. The patient had an area of course infiltrate or atelectasis in this region on previous chest film of September of 1997. No hilar or mediastinal adenopathy is seen. I do not have any recent plain films of the chest available for comparison. Impression: Findings are consistent with CWP. There are some confluent densities in the upper apices bilaterally with the right being greater than the left. These have the appearance of very early coalescence of nodules to form complicated CWP. (CX 1).

[17] Claimant also submitted a medical report dated April 6, 2004, (CX 6), which appears to be a photocopy of the September 27, 2004 report, with exception of the date. He also submitted a medical report dated March 17, 2004, (CX 7), which does not appear to be a photocopy of the September 27, 2004 report, but includes identical answers to each question. Since all three of these reports state exactly the same information, and Claimant did not designate the March 17, 2004 or April 6, 2004 report as one of his two reports under the limitations of § 725.414 (a)(3), I will consider only the September 27, 2004 report.

[18] Claimant submitted credentials for several of the physicians included in the CT scans and treatment records: Dr. Alexander Poulos is a radiologist and B-reader; Dr. Denis Halbert is a radiologist and B-reader; Dr. William Kendall is a B-reader; and Dr. Larry West is a radiologist and B-reader. (CX 4).

January 13, 2000 – CT Scan report by Dr. Fino dated September 29, 2004: Progression from the previous CT scan. There are more nodular densities consistent with simple CWP, and a developing right upper lobe large opacity. (EX 2).

January 13, 2000 – CT Scan report by Dr. Wiot dated October 8, 2004: The CT findings could represent metastic disease. (EX 7).[19]

January 13, 2000 – Initial examination by Dr. Rogers: Patient was referred by Dr. Mettu. Recently had a CT scan which reveals apical changes consistent with complicated CWP, right greater than left. (CX 1).[20]

August 8, 2000 - CT Scan report by Dr. Alexander Poulos: Compared to the 1/13/2000 study, there has been no gross interval change. Again, small rounded opacities are seen throughout both lung fields which dominate in the upper lung zones. There is again the presence of areas of coalescence that have developed in both upper apices that remain stable in appearance. Coalescence in the right apex continues to be slightly larger than noted on the left. Small nonspecific infiltrate of the posterior lateral aspect of the right lower lung remains stable and associated with slight tenting of the pleural surface. This may represent chronic disease. No new lesions have developed elsewhere in either lung. Mediastinal and hilar structures remain stable with no evidence of adenopathy or masses. Impression: There continues to be findings compatible with CWP which remains stable in appearance. There is again the presence of areas of coalescence in the upper lung zones that remain stable in appearance. No active disease is noted at this time. (CX 1).

August 8, 2000 – CT Scan report by Dr. Fino dated September 29, 2004: Not significantly different from the scan performed on January 13, 2000. (EX 2).

August 8, 2000 – CT Scan report by Dr. Wiot dated November 13, 2003: Showed "q" and "t" sized opacities, but these nodules ran along the bronchovascular markings, which is a common finding in sarcoidosis. Also, there was no adenopathy, and the mass in the right upper zone was not the kind seen with CWP, but is much more classical for sarcoidosis. (EX 8). [21]

November 13, 2003 - CT Scan report by Dr. Dennis Halbert – There are numerous small nodular densities present throughout the lungs which are consistent with those seen in CWP. There is a small mass lesion seen in the right apex. The central portion of the mass measures

[19] Concerning this CT scan, Dr. Wiot goes on to conclude that Claimant does not suffer from metastic disease nor CWP because they do not progress this rabidly, but instead has sarcoidosis. Since Dr. Wiot's report is based on 12 x-rays that are not admissible into evidence under the limitations of §725.414, they were not designated as direct evidence by Employer, nor were they properly designated as rebuttal evidence because the original x-rays were not designated by Claimant. Therefore, since Dr. Wiot based his conclusions concerning this CT scan on "the sequence of events," and the "chest x-rays and CT scans all together as a group," these conclusions are inadmissible.

[20] As this report was generated as part of Dr. Rogers' initial consultation with Claimant, it does not appear that he actually conducted the CT scan, but instead was either reviewing the results, or another physician's interpretations. Also, this report does not reference which CT scan Dr. Rogers was reviewing when he made his diagnosis, only a "recent" scan.

[21] Dr. Wiot was deposed on December 9, 2003, continuing on October 25, 2004, where he reiterated the findings of his prior written report. (EX 8).

approximately 2.5 x 1 cm. The peripheral margin is speculated in appearance and it is roughly parallels the chest wall. This is typical in appearance for a large opacity seen in complicated CWP. Small nodular opacities are also consistent with CWP. There are two small nodules seen in the right mid lung zone which are slightly larger than the other nodules present. These are in the range of 6 to 7 mm in diameter. They do not contain any obvious calcification. A small infiltrate is seen abutting the chest wall along the lower right lateral chest. There are several small nodes in the mediastinum and both hila. None of the nodes appear to be over 1 cm in diameter. Impression: films are consistent with complicated CWP with multiple small nodules. The small mass in the right apex is most consistent with a large opacity seen in complicated CWP. However, we do not have any previous studies available to confirm stability. Differential for the mass would also include neoplasm. Additionally, there are two small nodules in the right mid lung zone which are larger than the other nodules in the chest. Both of these are less than 1 cm in diameter and are of uncertain significance. (CX 1).

March 9, 2004 – CT scan report by Dr. Poulos: Compared to the 11/3/2003 study, there is again the presence of small nodular densities noted throughout both lung fields with the highest concentration being in the mid and upper lung zones. There is again the presence of a larger opacity in the right upper lobe, surrounded by numerous nodules. This lesion continues to measure approximately 1 x 2.5 cm in size. Two small nodules noted in the right mid lung zone also remain stable measuring approximately 6-7 mm in diameter. Small nodular infiltrate abutting the lateral aspect of the right lower chest wall is also stable. Mild emphysematous changes are noted bilaterally. Small nodes are again seen in the nedisatinal and hilar regions. They continue to measure no greater than 1 cm. Impression: Stable nodular disease noted throughout both lung fields. Again, these changes are felt to probably represent complicated CWP with an area of progressive massive fibrosis that appears to be stable in the right apex. No new pathology has developed since the previous examination. (CX 7).

March 9, 2004 – CT Scan report by Dr. Fino dated September 29, 2004: Similar to the scan performed on September 8, 2004. (EX 2).

August 4, 2004 - CT scan report by Dr. Basim Antoun, a radiologist: Conducted a CT scan as part of Dr. Forehand's complete pulmonary examination. Dr. Antoun found bilateral apical and central interstitial lung thickening more pronounced on the right. He also found a poorly defined area of partial enhancement in the middle of the lung parenchyma of the right upper lobe, but noted that there was no visible hilar ormediastinal mass or lymphadenopathy. Impression: Bilateral apical and central interstitial lung thickening, and central area of approximately 2 cm diameter of irregular density with minimal enhancement in the right upper lobe is present. Dr. Antoun concluded that the findings could represent chronic interstitial fibrosis with a central scar in the right upper lobe. (CX 5).

August 4, 2004 - CT scan summary by Dr. Forehand: complicated CWP, and rules out infectious, granulomatous [scaroid] and malignant conditions. (CX 3, 5).

September 8, 2004 – CT Scan report by Dr. Fino dated September 29, 2004: Nodular densities were seen in the upper lung zones. The largest was approximately 1.c cm in diameter in the right upper zone. (EX 2).

Hospitalization Records and Treatment Notes[22]

The record includes the following hospitilazation records and treatment notes, reproduced here in chronological order: Pikeville Methodist Hospital (CX 1); Dr. Rogers Treatment notes (CX 1); Pathology & Cytology Laboratories (CX 1); and Dr. Mettu Treatment notes (CX 7).

January 5, 2000 – Treatment note by Dr. Mettu: Patient has been coughing with thick expectoration, and has symptoms of chronic bronchitis and sleep apnea. His chest has been tight lately, and he has exertional shortness of breath. On examination the lungs are clear. (CX 7).

January 20, 2000 – Treatment note by Dr. Mettu: Patient has a history of chronic bronchitis, and was seen because of an abnormal chest x-ray. A CT scan revealed findings in the chest consistent with pneumoconiosis, but we are not sure at this time about the progress of the disease. Lungs are clear. (CX 7).

January 24, 2000 – Treatment note by Dr. Mettu: Current x-ray shows bilateral difused nodules that look more like CWP. CT scan revealed findings more of pneumoconiosis. However, there are some new changes from the 1993 x-ray. (CX 7).

February 17, 2000 – Initial examination by Dr. Rogers: Patient was referred by Dr. Mettu. Recently had a CT scan which reveals apical changes consistent with complicated CWP, right greater than left. He has smoked 1 pack per day for 18 years and has worked in the coal mines. He had a negative bronchoscopy by Dr. Brody in 1996. On examination, his lungs were decreased in the bases. Impression: Patient has bilateral apical changes, right greater than left, which appear to be consistent with complicated CWP, as indicated by the CT scan. (CX 1).

February 22, 2000 – Follow up note by Dr. Mettu: Patient has symptoms of chronic bronchitis and shortness of breath. X-ray revealed bilateral upper lobe nodule. On examination the lungs are clear. At this time Dr. Rogers thinks the nodule is most likely due to pneumoconiosis but cannot exclude malignancy. Patient is going to have a bronchoscopy conducted. (CX 7).

February 24, 2000 – Bronchial scope report by Dr. Tamara Sanderson: Negative for malignant cells, both right and left upper lobe. Comment: many histocytes and few bronchial dells are present. (CX 1).

[22] The hospital treatment records and treatment notes submitted by Claimant contain several interpretations of various x-rays. While Claimant has presented evidence as to the x-ray reading credentials of most of these physicians, the results are not in compliance with the quality standards of §718.102 and Appendix A to Part 718. First, these interpretations were all related to the treatment of Claimant's condition, and not for the purpose of determining the existence or extent of pneumoconiosis, so they are not classified according to the ILO standard. Also, there is no record of the film quality for any of these x-rays. As a result, despite the fact that the records submitted by the Claimant unanimously suggest both simple and complicated pneumoconiosis, I am not able to accord these x-ray interpretations any weight for the purpose of determining whether Claimant suffers from simple or complicated pneumoconiosis.

March 1, 2000 – Treatment report and note by Dr. Mattu: States to Dr. Nichols that patient's bronchoscopy revealed no endobronchial lesion, and the bronchoscopy was essentially negative. Also his bronchial washings are negative for any malignancy cells. Lungs are clear. (CX 7).

May 5, 2000 – Follow-up examination by Dr. Rogers: Patient states he is feeling well. He had a bronchoscopy by Dr. Mettu, which, so far, has been negative. On examination, his lungs are decreased in the bases. Patient appears to be stable. (CX 1).

July 17, 2000 – Treatment note by Dr. Mattu: Patient presented claiming to not feel well. Examination shows heart and lungs to be unremarkable. Impression: Sleep apnea symptomatic. (CX 7).

June 21, 2000 – Treatment report by Dr. Mattu: States to Dr. Nichols that patient has symptoms of chronic bronchitis and had an abnormal chest x-ray with pneumoconiosis. After review of the records, I conclude that patient has pneumoconiosis in the right upper lobe. Impression: Sleep apnea and COPD. (CX 7).

August 17, 2000 - Follow-up examination by Dr. Rogers: Patient has been doing approximately the same and continues to follow up with Dr. Mettu. On examination, his lungs are decreased in the bases. Patient appears to be stable. (CX 1).

September 13, 2000 – Consultation by Dr. Mattu: Patient has sleep apnea and symptoms of chronic bronchitis. On examination his lungs are clear. (CX 7).

October 9, 2000 – Treatment note by Dr. Mattu: Patient presented with shortness of breath on exertion. He has symptoms of chronic bronchitis and a history of COPD and black lung disease. On examination the lungs are clear. Impression: Shortness of breath, chronic bronchitis, pneumoconiosis. (CX 7).

December 6, 2000 - Treatment report by Dr. Srinivasu Ammisetty: Patient is doing fine and but has no cough and productive sputum. Chest examination reveals decreased airflow but no wheezing. Diagnosis: Obstructive sleep apnea, COPD, and episodes of shortness of breath with exertion. Note: I checked the pulse oxysaturation. Today his room air saturation is 96 and pulse is 78. On exertion with three blocks of brisk walking his saturation is 98 and pulse is 97. There is no hypoxemia. (CX 7).

February 8, 2001 – Treatment note by Dr. Srinivasu Ammisetty: Patient is doing fine and has a cough but no productive sputum, fever or chills. On examination his chest was clear. Assessment: Obstructive sleep apnea, COPD, and episodes of shortness of breath with exertion. (CX 7).

March 1, 2001 - Follow-up examination by Dr. Rogers: Since last visit, patient continues to have shortness of breath, but has no other symptoms. He continues to follow up with Dr. Mettu. On examination, his lungs are decreased in the bases. Chest x-ray is stable. Patient appears to be stable. (CX 1).

May 7, 2001 – Treatment note by Dr. Mettu: Lately he has been having trouble with shortness of breath. He has a history of COPD, black lung, and sleep apnea. Examination showed the lungs to be clear. (CX 7).

October 22, 2001 – Treatment note by Dr. Mettu: Patient complained of pain in the right lower chest especially with deep breaths. He has shortness of breath on exertion. On examination the lungs were clear. Impression: right side lower chest pain, history of shortness of breath, COPD. (CX 7).

August 29, 2002 – Treatment note by Dr. Mettu: Patient has sleep apnea and chronic bronchitis. He has exertional shortness of breath, but seems to be comfortable at rest. No history of PND or chest pain. He has symptoms of chronic bronchitis. On examination, his lungs are clear. Impression: COPD and obstructive sleep apnea. (CX 7).

October 10, 2002 – Chest x-ray report by Dr. William Kendall: There are small interstitial nodular densities predominantly within the mid and upper lung zones which appear unchanged from the prior examination. There is an approximately 2 cm confluent opacity in the right upper lobe which appears stable when compared to prior examination. The lungs are otherwise clear and the cardiac silhouette and pulmonary vasculature is within normal limits. Impressions: Findings consistent with complicated CWP, unchanged from prior examination. (CX 1).

November 21, 2002 - Follow-up examination by Dr. Rogers: Since last visit, patient continues to have severe shortness of breath that leads to sleeping troubles. He continues to follow up with Dr. Mettu and Dr. Nicholas. On examination, his lungs are decreased in the bases. Chest x-ray reveals changes consistent with severe CWP. Assessment: Patient has severe CWP. He is severely symptomatic from that with shortness of breath. I think he is completely disabled at this time and in the foreseeable future. (CX 1).

November 25, 2002 – Examination report by Dr. Mettu: On examination the lungs were clear. Impression: COPD, history of black lung, sleep apnea. (CX 7).

January 2, 2003 - Follow-up examination by Dr. Rogers: Patient continues to have significant shortness of breath and other problems. On examination, his lungs are decreased in the bases. Patient is stable. (CX 1).

June 19, 2003 – Follow-up report by Dr. Rogers: He does have shortness of breath. Lung examination reveals decreased in the bases. Chest x-ray appears to be stable. (CX 8).

June 19, 2003 – Follow up examination by Dr Rogers: He has shortness of breath but no hemoptysis, and chest x-ray appears to be stable. Will get a CT scan in five months. (CX 1).

June 20, 2003 – X-ray report by Dr. Halbert: 6/19/03 film shows nodular densities throughout all lung zones and are most prevalent in the right upper chest. There appears to be coalescence of the nodules in the right apex. The appearance suggests CWP. Impression: Findings are most consistent with CWP. Since I do not have any acute films, I cannot exclude an acute process with complete certainty. (CX 1).

December 17, 2003 – Report by Dr. Nichols: Claimant contends that this is a report by Dr. Nichols stating no scaroidiosis. The report, however, does not mention scaroidiosis, nor does it state that Mr. Bentley is negative. (CX 1).

January 17, 2004 – Report by Dr. Nichols: Claimant contends that this is an updated report by Dr. Nichols stating that he is negative for scaroidiosis. While the report does state that Mr. Bentley's "ANA SCREEN" is "NEGATIVE," the report says nothing about scaroidiosis. (CX 7).

February 2, 2004 – Radiology report by Dr. Alexander Poulos: Compared with the 6/19/2003 study, there is no gross interval change. There are three rounded opacities noted throughout both lung fields with large opacity or mass noted in the right upper lobe that is stable. No acute areas of infiltrate or pleural pathology is noted. Impression: stable fibronodular disease noted throughout both lung fields compatible most likely with coal workers' pneumoconiosis. Large opacity or mass noted in the right upper lobe is stable and probably represents an area of progressive massive fibrosis from complicated coal workers' pneumoconiosis. (CX 1).

Smoking History

At the deposition Claimant testified that he smoked one pack per day for the last 18 years. (DX 22:12). At the hearing, however, he testified that he currently smokes about a pack per day, and has smoked on and off for 28 years. (Tr. 27). Dr. Hussain reported that Claimant smoked 29 years at a rate of 1/2 pack per day, and continued to smoke at the time of his 2001 examination. (DX 9). Dr. Forehand reported that Claimant had 33 pack years of cigarette smoking, and continued to smoke at the time of his 2004 examination. (DX 5). Dr. Fino reported that Claimant had 26 pack years of cigarette smoking, at a rate of one pack per day, and continued to smoke at the time of his 2004 examination. (EX 2). Dr. Dahhan reported a 32 pack-year smoking history, and Claimant continues to smoke. (EX 4).

According to the evidence in the record, Claimant's smoking history falls somewhere between a minimum of 14.5 pack-years, according to Dr. Hussain, to a maximum of 33 pack years, based on the report by Dr. Forehand. I presume that the Claimant would not purposely overstate his smoking history, thereby presenting a possible detriment to his own case. As a result, I find Dr. Forehand's report as to length of cigarette smoking to be the most persuasive and find that the Claimant has smoked for 33 pack-years, and continues to smoke at a rate of one pack per day.

DISCUSSION AND APPLICABLE LAW

Mr. Bentley's claim was made after March 31, 1980, the effective date of Part 718, and must therefore be adjudicated under those regulations. To establish entitlement to benefits under Part 718, Claimant must establish, by a preponderance of the evidence, that he:

1. Is a miner as defined in this section; and

2. Has met the requirements for entitlement to benefits by establishing that he:

(i) Has pneumoconiosis (see § 718.202), and

(ii) The pneumoconiosis arose out of coal mine employment (see § 718.203), and

(iii) Is totally disabled (see § 718.204(c)), and

(iv) The pneumoconiosis contributes to the total disability (see § 718.204(c)); and

3. Has filed a claim for benefits in accordance with the provisions of this part.

Section 725.202(d)(1-3); *see also* §§ 718.202, 718.203, and 718.204(c).

Pneumoconiosis

In establishing entitlement to benefits, Claimant must initially prove the existence of pneumoconiosis under § 718.202. Claimant has the burden of proving the existence of pneumoconiosis, as well as every element of entitlement, by a preponderance of the evidence. *See Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994). Pneumoconiosis is defined by the regulations:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis.
>
> (1) *Clinical Pneumoconiosis*. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) *Legal Pneumoconiosis*. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For the purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

Sections 718.201(a-c).

Section 718.202(a) sets forth four methods for determining the existence of pneumoconiosis.

(1) Under § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence. The record contains 14 interpretations of 11 chest x-rays and one quality-only interpretation. Seven of these films, however, were interpreted by eight physicians as part of Claimant's prior hospitalizations and treatments. Therefore, they cannot be used for determining whether he suffers from pneumoconiosis because they do not meet the quality standards of §718.102.[23] Also, Dr. Wiot's interpretation of the November 16, 2001 film, and Dr. Fino's interpretations of the August 4, 2004 and September 8, 2004 films would be taken out of context it they were utilized to determine the existence of simple or complicated pneumoconiosis under §718.202 (a)(1).[24] Therefore, there are three only three interpretations of three films, and one quality-only interpretation that remain to be considered under subsection (a)(1).

Dr. Hussain interpreted the November 16, 2001 chest x-ray as positive for simple pneumoconiosis. There is neither any complicated pneumoconiosis nor negative interpretations of this film. Therefore, I find the November 16, 2001 film is positive for simple pneumoconiosis.

Dr. Dahhan, a B-reader, interpreted the October 14, 2003 chest x-ray as positive for simple pneumoconiosis. There is neither any complicated pneumoconiosis nor negative interpretations of this film. Therefore, I find the October 14, 2003 film is positive for simple pneumoconiosis.

Dr. Forehand, a B-reader, interpreted the August 4, 2004 chest x-ray as positive for both simple and complicated pneumoconiosis. There is no negative reading of this film. Therefore, I find the August 4, 2003 film is positive for both simple and complicated pneumoconiosis.

I have determined that all three of the x-rays in evidence are positive for simple pneumoconiosis, but only one of the three is positive for complicated pneumoconiosis. An administrative law judge is not required to defer to the numerical superiority of x-ray evidence, *Wilt v. Wolverine Mining Co.,* 14 B.L.R. 1-70 (1990), although it is within his or her discretion to

[23] *See* note 22 for an explanation of why theses interpretations fail under §718.102. X-rays interpretations which are admissible but cannot be considered for determining the existence of pneumoconiosis include: Dr. Mettu's January 24, 2000 and February 22, 2000 interpretations; Dr. Rogers' March 1, 2001, November 21, 2002, and June19, 2003 interpretations; Dr. Kendall's October 10, 2002 interpretation; Dr. Halbert's June 19, 2003 interpretation; and Dr. Poulos' February 2, 2004 interpretation. I will again note that Employer has listed a number of rebuttal interpretations of x-rays not designated by the employer. Two of these interpretations are rebuttals of the October 10, 2002 and the June 19, 2003 films. These interpretations also cannot be considered for the purpose of determining the existence of pneumoconiosis for the reasons stated in note 22.

[24] *See* note 10-12 above.

do so, *Edmiston v. D & R Coal Co.,* 14 B.L.R. 1-65 (1990). The Sixth circuit, however, has stated that an administrative law judge "simply cannot consider the quantity of evidence alone, without reference to a difference in the qualification of the readers or without an examination of the party affiliations of the experts." *Woodward v. Director, OWCP,* 991 F.2d 314 (6th Cir. 1993). Based on the fact that the B-readers who interpreted the films are split as to whether Claimant suffers from complicated pneumoconiosis, and the deciding vote is cast by a physician without B-reader credentials, it would not be appropriate to base the determination of whether Claimant suffers from simple or complicated pneumoconiosis based on numerical superiority. This is because the balance would shift based on the interpretation of the least qualified physician. Thus, while I have determined that one x-ray is positive for both simple and complicated pneumoconiosis, but two are positive for only simple pneumoconiosis, I exercise my discretion and decline to accord it greater probative weight to the numerical superiority.

Also, I have determined that the most recent film was positive for both simple and complicated pneumoconiosis. It is proper to accord the most recent chest x-ray greater probative weight based on the definition of pneumoconiosis as a latent and progressive disease. *Clark v. Karst-Robbins Coal Co.,* 12 B.L.R. 1-149 (1989)(en banc). However, even if the most recent x-ray is positive, the administrative law judge is not required to accord it greater weight. Rather, the length of time between the x-ray studies and the qualifications of the interpreting physicians are factors to be considered. *McMath v. Director*, OWCP, 12 B.L.R. 1-6) 1988); *Pruitt v. Director, OWCP*, 7 B.L.R. 1-544 (1984); *Gleza v. Ohio Mining Co.,* 2 B.L.R. 1-436 (1979). In this case both films were interpreted by B-readers within a period of ten months. While ten months may be a sufficient time period to apply the "later evidence" rule, the record does not indicate a progression in the classification of Miner's level of pneumoconiosis after 2000. Also, keeping in mind the number of x-ray interpretations that have been excluded from consideration for one reason or the other, it would be inappropriate for the undersigned to apply the "later evidence" to the three surviving x-rays out of 14 initially accepted into the record. Thus, while I have determined that the most recent chest x-ray revealed the presence of a large-size opacity, I exercise my discretion and decline to accord it greater probative weight.

Finally, considering the interpretation credentials of the physicians reading the x-rays, I find that both Dr. Dahhan and Dr. Forehand are B-readers. Therefore their interpretations should be given more weight than the interpretation by Dr. Hussain, who is neither a B-reader nor a radiologist. Furthermore, since Drs. Dahhan and Forehand are split as to their opinions of whether Claimant suffers from simple or complicated pneumoconiosis, I find that the x-ray evidence is inclusive for the presence of complicated pneumoconiosis.

Therefore, I find that the x-rays are unanimous in finding that Claimant has established the presence of simple pneumoconiosis under subsection (a)(1), but that he has failed to prove the presence of complicated pneumoconiosis by a preponderance of the evidence.

(2) Under § 718.202(a)(2), a determination that pneumoconiosis is present may be based, in the case of a living miner, upon biopsy evidence. The evidentiary record does not contain any biopsy evidence. Therefore, I find that the Claimant has failed to establish the existence of pneumoconiosis through biopsy evidence under subsection (a)(2).

(3) Section 718.202 (a)(4) provides in pertinent part:

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

§ 718.202(a)(4).

This section requires a weighing of all relevant medical evidence to ascertain whether or not the claimant has established the presence of pneumoconiosis by a preponderance of the evidence. Any finding of pneumoconiosis under § 718.202(a)(4) must be based upon objective medical evidence and also be supported by a reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which he bases his diagnosis. *Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985). A brief and conclusory medical report which lacks supporting evidence may be discredited. *See Lucostic v. United States Steel Corp.*, 8 B.L.R. 1-46 (1985); *see also*, *Mosely v. Peabody Coal Co,.* 769 F.2d 257 (6th Cir. 1985). Further, a medical report may be rejected as unreasonable where the physician fails to explain how his findings support his diagnosis. *See Oggero*, 7 B.L.R. 1-860.

The evidentiary record contains five narrative medical opinions by examining physicians, one of which is also a treating physician. Dr. Hussain determined that based on the chest x-ray, physical examination, PFT, and ABG results, Claimant suffered from pneumoconiosis due to dust exposure. His ABG and PFT test results were non-qualifying under DOL standards. Also, while Dr. Hussain accredited Claimant's condition to coal mine employment, he did not mention the length of coal mine employment he considered in reaching his conclusion, nor did he discuss the impact of cigarette smoking on Claimant's condition. It is proper for an ALJ to discredit a medical opinion based on an inaccurate length of coal mine employment. *Worhach v. Director, OWCP*, 17 B.L.R. 1-105 (1993)(per curiam) (physicians reported an eight year coal mine employment history, but the ALJ only found four years of such employment); *Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993) (physician's opinion less probative where based on inaccurate smoking history). Furthermore, an unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-292 (1984). *See also Phillips v. Director, OWCP*, 768 F.2d (8th Cir. 1985); *Smith v. Eastern Coal Co*., 6 B.L.R. 1-1130 (1984); *Duke v. Director, OWCP*, 6 B.L.R. 1-673 (1983)(a report is properly discredited where the physician does not explain how underlying documentation supports his or her diagnosis); *Waxman v. Pittsburgh & Midway Coal Co.,* 4 B.L.R. 1-601 (1982). Since Dr. Hussain failed to record any specific length of coal mine employment, he considered less than half the actual length of cigarette smoking, and he did not explain why he accredited Claimant's condition entirely to coal dust exposure at the exclusion of cigarette smoking, I find that his opinion is

neither well-reasoned nor well-documented. As a result, I accord his opinion little probative weight for determining the presence of pneumoconiosis under subsection (a)(4).

Dr. Dahhan opined that based on 16 years of coal mine employment, a 32 pack-year smoking history, an insignificant physical exam, normal PFT, ABG, and EKG results, and a 2/2 x-ray, that Claimant suffered from simple CWP. Dr. Dahhan based his diagnosis on the underlying objective data, and therefore I find his opinion to be well-reasoned and-well documented. As a result, based on his advanced credentials as an internist, pulmonologist, and B-reader, I accord his opinion probative weight.

Dr. Forehand determined that based on 16 years of coal mine employment, a normal physical examination and PFT, an ABG that revealed evidence of exercise-induced hypoxemia, an x-ray, and a CT scan, that Claimant suffered from complicated CWP. It should also be noted that while Dr. Forehand made no mention of the impact of Claimant's 33 pack-years of cigarette smoking, smoking history is not relevant to a diagnosis of complicated pneumoconiosis based upon CT scan results and x-ray interpretations. Therefore, I find his opinion to be well-reasoned and-well documented. As a result, based on his advanced credentials as a B-reader, I accord Dr. Forehand's opinion probative weight.

Dr. Fino opined, based on 16 years of coal mine employment, 26 pack-year history of cigarette smoking, a physical examination, three x-ray interpretations, a non-qualifying PFT, a normal ABG, and a rereading of five CT scans, Claimant did not suffer from either simple or complicated pneumoconiosis. This diagnosis was also based on medical records review. However, since his review included a large amount of evidence that was determined to be inadmissible, his conclusions concerning the existence of simple and complicated pneumoconiosis can be given no probative weight. Dr. Fino's review of the individual CT scans is admissible, and will be discussed below.

Dr. Rogers, Claimant's treating physician for the past five years. An administrative law judge may rely upon the well-reasoned and well-documented opinion of a treating physician as substantial evidence in awarding that physician's opinion controlling weight based upon four factors: (1) nature of relationship; (2) duration of relationship; (3) frequency of treatment; and (4) extent of treatment. § 718.104(d) (2002). "[T]he opinions of treating physicians are not necessarily entitled to greater weight than those of non-treating physicians in black lung litigation." *Eastover Mining Co. v. Williams*, 338 F.3d 501 (6th Cir. 2003). "[I]n black lung litigation, the opinions of treating physicians get the deference they deserve based on their power to persuade." *Id*. at 510; 20 C.F.R. § 718.104(d). "A highly qualified treating physician who has lengthy experience with a miner may deserve tremendous deference, whereas a treating physician without the right pulmonary certifications should have his opinion appropriately discounted." *Id*. In addition, appropriate weight should be given as to whether the treating physician's report is well-reasoned and well-documented. *See Peabody Coal Co. v. Groves*, 277 F.3d 829 (6th Cir. 2002); *McClendon v.Drummond Coal Co.*, 12 B.L.R. 2-108 (11th Cir. 1988).

Dr. Rogers determined that Claimant suffered from both clinical and legal pneumoconiosis with progressive fibrosis, as well as complicated pneumoconiosis with progressive fibrosis. Dr. Rogers state that he relied on x-ray evidence to make his determination, but he never designated which x-rays he relied upon. Also, his report did not discuss a specific

length of coal mine employment, exposure to tobacco smoke, nor any additional objective testing relied upon to reach his diagnosis. Therefore, based on his failure to identify any objective data to support his conclusions concerning simple or complicated pneumoconiosis, or legal or clinical pneumoconiosis, I find his report to unreasoned and poorly documented. Therefore, despite his status as Claimant's treating physician, I accord Dr. Rogers' opinion little probative weight.

The record also includes 14 interpretations of seven CT scans by seven physicians. Concerning CT scans, at present, "[t]he clinical diagnosis and follow up of pneumoconiosis in most workforces at risk for pneumoconiosis are still based on the changes in the lung visible by standard X-ray techniques." *Consolidation Coal Co. v. Director, OWCP*, 294 F.3d, 885, 892 (7th Cir. 2002)(quoting Q.T. Pham, *Chest Radiography in the Diagnosis of Pneumoconiosis*, 5(5) INT. J. TUBERC. LUNG DIS. 478 (2001)). As a result, the Department of Labor has rejected the view that a CT-scan, by itself, "is sufficiently reliable that a negative result effectively rules out the existence of pneumoconiosis." 65 Fed. Reg. 79, 920, 79, 945 (Dec. 20, 2000). CT scans, however, when evaluated by qualified experts are "important diagnostic tools that have resulted in major improvements in the assessment of occupational lung disease." *Consolidation Coal* 294 F.3d 892. Such qualified experts are generally "radiologists (some of whom may in addition be classified as B readers) who have specialized knowledge and have developed a certain expertise through years of training and experience interpreting this particular test." *Id*. at 894 (citing J.F. Wiot & O. Linton, *The Radiologist and Occupational Lung Disease*, 175(2), AM. J. ROENTGEN. 311 (2000)). A pulmonologist may have the knowledge, training and experience to review a CT scan and reliably discuss whether the test discloses the presence of pneumoconiosis, but a party must qualify an individual pulmonologist as such an expert. *Id*. Further, the results of a CT scan must be interpreted in conjunction with the occupational history, clinical examination, pulmonary function tests, x-rays, arterial blood gas tests and the reasoned opinions of all the experts and physicians. *Id*. at 892.

The June 25, 1996 CT scan was evaluated by Dr. Fino, a B-reader, and determined to be consistent with simple CWP. Since there were no other interpretations of this scan, I find that it is positive for simple CWP.

The January 13, 2000 CT scan was evaluated by Dr. Halbert, a radiologist and B-reader, and Dr. Fino, a B-reader. Both physicians determined the scan results to be consistent with simple CWP. Dr. Wiot, a radiologist and B-reader, also evaluated this CT scan and determined that it could represent metastic disease. Dr. Wiot, however, ultimately concluded that this CT scan represented sarcoidosis, but since that conclusion was considered inadmissible evidence, his determinations concerning this CT scan are also inadmissible. *See* note 19. Finally, Dr. Rogers stated in his initial examination of Claimant that a CT scan had recently been conducted. He stated that the scan revealed apical changes consistent with complicated CWP. I place more weight on the findings of Drs. Fino and Halbert, based on their advanced credentials, than I do on the opinion of Dr. Rogers. Therefore, I find that the January 13, 2000 CT scan is positive for simple CWP, but does not reflect the presence of complicated pneumoconiosis.

The August 8, 2000 CT scan was evaluated by Drs. Poulos and Wiot, radiologists and B-readers, and by Dr. Fino, a B-reader. Drs. Poulos and Fino determined that the scan was positive for simple CWP. Dr. Wiot, on the other hand, found the scan to be negative for simple or

complicated CWP, but instead concluded that the results were much more classical for sarcoidosis. Due to the fact that Dr. Poulos and Dr. Wiot have the same interpretation credentials, I find that the August 8, 2000 CT scan is inconclusive for the existence of pneumoconiosis.

The November 13, 2003 CT scan was evaluated by Dr. Halbert, a radiologist and B-reader. He determined that the 2.5 x 1 cm. mass lesion was typical in appearance for a large opacity, and thus Claimant suffered from both simple and complicated CWP. Since there were no other interpretations of this scan, I find that it is positive for both simple and complicated CWP.

The March 9, 2004 CT scan was evaluated by Dr. Poulos, a radiologist and B-reader, and Dr. Fino, a B-reader. Dr. Poulos concluded that the scan results "probably" represented complicated CWP. Dr. Fino, however, stated that the results were similar to the September 8, 2004 scan, in which he noted nodular densities, but failed to make a conclusion concerning either simple or complicated pneumoconiosis. An opinion may be given little weight if it is equivocal or vague. *Griffith v. Director, OWCP*, 49 F.3d 184 (6th Cir. 1995) (treating physician's opinion entitled to little weight where he concluded that the miner 'probably had black lung disease). As a result, I find Dr. Poulos' opinion to be equivocal, and therefore accord it little weight. And since Dr. Fino did not articulate a specific finding concerning this scan, I am unable to determine whether the March 9, 2004 scan is positive or negative for either simple of complicated pneumoconiosis.

The August 4, 2004 CT scan was evaluated by Dr. Antoun, a radiologist, and Dr. Forehand, a B-reader. While Dr. Antoun did specifically state that Claimant suffers from complicated pneumoconiosis, he did note an approximately 2 cm diameter of irregular density in the right upper lobe. Dr. Forehand, on the other hand, was quite specific, diagnosing complicated CWP, and ruling out infectious, granulamatous (sarcoid) and malignant conditions. Therefore, based on Dr. Forehand's definitive evaluation of the CT scan, and the fact that Dr. Antoun's report appears to support his conclusion, I find that the August 4, 2004 CT scan is positive for complicated CWP, and rules out sarcoid.

The September 8, 2004 CT scan was interpreted by Dr. Fino, a B-reader. While Dr. Fino identified densities in the upper right zones, up to approximately 1 cm in diameter, he made no definite conclusions regarding the existence of CWP. Therefore, I do find the September 8, 2004 to be neither positive nor negative for the existence of simple or complicated CWP.

I have found that Dr. Dahhan's narrative medical opinion diagnosing simple CWP is reasoned. Also, I have found Dr. Forehand's medical report, which diagnosis complicated CWP, to be well-reasoned. These reports are both entitled to probative weight. In addition, I have found that the June 25, 1996 and January 13, 2000 CT scans are positive for simple pneumoconiosis, and that the November 13, 2003 and the August 4, 2004 CT scans are positive for simple and complicated pneumoconiosis. Therefore, since all of the reasoned medical reports conclude that Claimant at least suffers from simple CWP, and only Dr. Wiot's CT scan interpretations state that Claimant does not suffer from any form of CWP, but are contradicted by

equally qualified physicians, I find that Claimant has proven by a preponderance of the evidence that he suffers from simple CWP by a preponderance of the evidence.

(4) The fourth and final way in which it is possible to establish the existence of pneumoconiosis arises under § 718.202(a)(3) which provides that pneumoconiosis may be established if any one of several cited presumptions are found to be applicable. In this case, the presumption of § 718.305 is not applicable to claims filed after January 1, 1982. Section 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982. Since this claim was filed in 2001, the presumption of §718.306 is not applicable

Section § 718.304 provides an irrebuttable presumption that a miner's total disability was due to pneumoconiosis if such miner suffered from a chronic dust disease of the lung which:

(a) When diagnosed by chest x-ray (*see* § 718.202 concerning the standards for X-rays and the effect of interpretations of X-rays by physicians) yields one or more large opacities (greater than 1 centimeter in diameter) and would be classified in Category A, B, or C; or

(b) When diagnosed by biopsy or autopsy, yields massive lesions in the lung; or

(c) When diagnosed by means other than those specified in paragraphs (a) and (b) of this section, would be a condition, which could reasonably be expected to yield the results described in paragraph (a) or (b) of this section had diagnosis been made as therein described: *Provided, however,* That any diagnosis made under this paragraph shall accord with acceptable medical procedures.

As stated in the analysis of §718.202 (a)(1) above, the x-rays are unanimous in finding that Claimant has established the presence of simple pneumoconiosis under subsection (a)(1), but that he has failed to prove the presence of complicated pneumoconiosis by a preponderance of the evidence. Therefore, I find that Claimant has failed to satisfy the requirements of § 718.304 (a).

There is no biopsy or autopsy evidence to consider under § 718.304(b).

As stated in the analysis of §718.202 (a)(4) above, there is one reasoned medical opinion finding simple pneumoconiosis, and one finding complicated pneumoconiosis. Also, two of the CT scans were positive for simple pneumoconiosis only, while two were positive for simple and complicated pneumoconiosis. In addition, I found the remaining three CT scans to be inconclusive for the existence of complicated pneumoconiosis.

This case presents a close call, with the ultimate determination coming down to whether, according to the radiologists, Claimant has sarcoidosis, as argued by Dr. Wiot, or complicated pneumoconiosis, as argued by Drs. Halbert, Poulos, and possibly Dr. Antoun. Also, Dr. Forehand is the only physician to attempt to contradict Dr. Wiot's scacoidosis CT scan reading. Based on credentials alone, I would find Dr. Forehand's B-reading insufficient to overcome Dr. Wiot's more qualified reading. However, since pneumoconiosis is a progressive disease, and all of the medical evidence, including the hospitalization records and treatment notes, demonstrate

an increase in severity since 2000, the "latter evidence" rule is applicable. Also, I find it convincing that even though Dr. Forehand is only a B-reader, the fact that he interpreted a CT scan almost four years subsequent to the last one reviewed by Dr. Wiot, and he specifically excluded the existence of sarcoidosis. Finally, I am further convinced by the fact that all of the radiologists who have reviewed subsequent CT scans to the August 8, 2000 scan, interpreted by Dr. Wiot, have either concluded that Claimant suffers from complicated pneumoconiosis, or in the case of Dr. Antoun, have not specifically excluded complicated pneumoconiosis. As a result, I find that while Dr. Wiot's diagnosis of sarcoidosis is convincing, I am more convinced by the fact that Dr. Forehand specifically ruled out sarcoidosis four years after Dr. Wiot's last CT scan reading, and that two additional radiologists reviewing scans three years subsequent to Dr. Wiot's, also concluded that Claimant suffers from complicated pneumoconiosis. This is further supported by fact that Dr. Forehand interpreted the results of a CT scan in conjunction with the occupational history, clinical examination, pulmonary function tests, x-rays, arterial blood gas tests and the reasoned opinion of Dr. Antoun. Finally, concerning Dr. Dahhan's medical report, I find that his conclusions concerning pneumoconiosis basically come down to a physical examination and an x-ray, and considering the value placed on CT scans by the radiologists of record, despite his qualifications as a internist and pulmonologist, I accord his reasoned opinion less weight that that of Dr. Forehand. Therefore, I find that Claimant has proven by the preponderance of the evidence that he suffers from complicated pneumoconiosis under § 718.304 (c).

Considering all of the evidence of complicated pneumoconiosis under § 718.304, I have found that Claimant has failed to prove complicated pneumoconiosis under subsection (a); that there was no biopsy or autopsy evidence to consider under subsection (b); and that Claimant has proven complicated pneumoconiosis by a preponderance of the evidence under subsection (c). Based on the fact that so many of the x-rays in the record were excluded due to evidentiary issues, leaving only three on which to base my determination, I find the more comprehensive series of CT scans and supporting narrative medical reports to be more probative to the issue of complicated pneumoconiosis. Therefore, I find that Claimant has proven the existence of complicated pneumoconiosis under §718.304.

Claimant has establish the presence of simple pneumoconiosis under subsection (a)(1) and (4), and he has triggered the irrebuttable presumption of § 718.304 by proving the presence of complicated pneumoconiosis. Therefore, I find that Claimant has established that he suffers from both simple and complicated pneumoconiosis.

Arising out of Coal Mine Employment

In order to be eligible for benefits under the Act, Claimant must also prove that pneumoconiosis arose, at least in part, out of his coal mine employment. § 718.203(a). For a miner who suffers from pneumoconiosis and was employed for ten or more years in one or more coal mines, it is presumed that his pneumoconiosis arose out of his coal mine employment. *Id.* As I have found that Claimant has established 14.62 years of coal mine employment, and as no rebuttal evidence was presented, I find that Claimant's pneumoconiosis arose out of his coal mine employment in accordance with the rebuttable presumption set forth in § 718.203(b).

Entitlement

Claimant, Danny Bentley, has established the existence of both simple and complicated pneumoconiosis arising out of coal mine employment. As a result, he has triggered the irrebuttable presumption of § 718.304, and is therefore totally disabled due to pneumoconiosis. Therefore, I find that Mr. Bentley is entitled to benefits under the Act. However, I cannot determine the month of onset of Mr. Bentley's total disability due to pneumoconiosis arising out of coal mine employment. Thus, benefits are payable to Mr. Bentley beginning with the month in which he filed his application for benefits. *See* § 725.503(b). Mr. Bentley filed his application for benefits in August 2001. Therefore, I find that benefits are payable to Mr. Bentley beginning in August 2001.

Attorney's Fees

No award of attorney's fees for services to Mr. Bentley is made herein, since no application has been received from counsel. A period of 30 days is hereby allowed for Mr. Bentley's counsel to submit an application, with a service sheet showing that service has been made upon all parties, including Claimant. The parties have 10 days following receipt of any such application within which to file their objections. The Act prohibits the charging of any fee in the absence of such approval. *See* §§ 725.365 and 725.366.

ORDER

IT IS ORDERED that the claim of Danny Bentley for benefits under the Act is hereby GRANTED.

A

THOMAS F. PHALEN, JR.
Administrative Law Judge

NOTICE OF APPEAL RIGHTS

Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date of this decision, by filing notice of appeal with the Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601. **A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, D.C. 20210.**